B. Vulnerable Adults

Contractor payment will be on a capitation firm fixed price basis. The upper limit for payment for services provided on a capitation basis shall be established by ascertaining what other third parties are paying for comparable services under comparable circumstances. The unit rate for state staff delivered services will be calculated based on historical costs.

Payment made for targeted case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

The contractor and the department will maintain an adequate audit trail to ensure that state match is nonfederal in origin, and that billed services were actually delivered. Documentation will be available for audit by authorized federal and state personnel.

C. Recipients who are high risk pregnant women and their infants living with them up to age one.

Payment will be on a fee-for-service basis. The upper limit for payment for services provided on a fee-for-service basis shall be based on an estimate of the fee for providing the services. The unit rates for state staff delivered services will be calculated based on historical costs.

Payments made for targeted case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: WASHINGTON

D. Recipients under age 21 (not already serviced by a case manager) whose family or caretaker needs assistance in accessing the health care system.

Payment will be on a fee-for-service basis. The upper limit for payment for services provided on a fee-for-service basis shall be based on a rate negotiated by the state Medicaid agency.

For state staff, the rate will be based on the cost of service: All the expenditures associated with the delivery of TCM within a defined time frame divided by all the TCM units of service provided.

Payments made for targeted case management services will not duplicate payments made to public agencies or private entities under other program authorities for the same purpose.

The provider will maintain adequate documentation to assure that services were provided as billed. Documentation will be available for audit by authorized federal and state personnel.

E. Services for Limited English Speaking (LES) recipients.

As outlined in this plan, coordinated case management services will be provided by contract providers.

1. All case management and supportive services will be tracked through the Medicaid agency's Division of Refugee Assistance (DORA) computerized case management information system. Medicaid agency social workers will maintain detailed case files of client activities and referrals to contracted providers who provide coordinated case management services.

2. Contractor payments will be based on a fee-for-service basis. The unit rate for delivered services will be adjusted annually based on historic costs and negotiated by DORA in each region.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
STATE: WASHINGTON

3. Contractor payments will be based on a fee-for-service basis. Payment for services will be based on budget cost of the Contractor. The unit rates for delivered self-sufficiency case management services will be based on historic costs and negotiated by DORA in each region.

4. All providers will maintain adequate documentation to assure that services were provided as billed. Documentation will be available for audit by authorized federal and state personnel.

5. This coordinated approach recognizes the different level of case management services for the targeted group serves and also maximizes the language coverage available to the population serves under this plan.

6 This process is coordinated through contracts, local agreements and, field manuals to CSOs and contracted providers staff.

7. Cost of services will be billed quarterly and reconciled to the financial and DORA Management Information System (MIS) records annually.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

XVI Hospice Services

Payment is made to a designated hospice provider based on a daily rate. The rates are contingent on the type of service provided that day. The rates are based on Medicaid guidelines and are wage adjusted.

Payment will not decrease on October 1, 1990 and increase again on January 1, 1991, but will continue at the October 1, 1990 level until such time as reimbursement levels are adjusted.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State Washington

XIV PERSONAL CARE SERVICES

A. Payment for Service

Payment for agency-provided services will be made on a reimbursement basis at an hourly unit rate. Agencies providing personal care services will be licensed home-care agencies. Each agency will submit monthly billings to Aging and Adult Services Administration for personal care services provided in each service area.

Payment for services provided by individual providers will be made directly to the provider via Social Service Payment System. Individual providers of personal care services will be under contract to the Department of Social and Health Services.

No payment will be made for services beyond the scope of the program or hours of service exceeding the department's authorization.

B. Service Rates

The hourly rate for agency-provided services is based on comparable service unit rates. The unit rate for agency-provided personal care increases above household-task and chore services due to necessary increased skill levels for home care aides, increased liabilities of provider agencies, and increased administrative costs due to nurse oversight coordination and aide-training activities.

The hourly rate for individual-provided personal care is based on comparable service unit rates. The unit rate for individual-provided personal care services increases above household tasks and chore services rates due to necessary increased skill levels for individual providers of personal care.

XVI FEDERALLY QUALIFIED HEALTH CARE CENTERS

Federally Qualified Health Care Centers are reimbursed for clinic services at a rate per encounter established for the clinic.

Encounter rates will be clinic specific and established by cost reports.

XVII **MEDICAL SERVICES FURNISHED BY A SCHOOL DISTRICT**

Reimbursement to school districts for medical services provided will be at the usual and customary charges up to a maximum established by the state.

XVIII **MENTAL HEALTH SERVICES**

Each community mental health provider participating in the Medicaid program is required to submit a cost report. These cost reports are aggregated, subjected to statistical tests, and the resulting information is used to determine a cost-based rate for each provider. These rates are arrayed, from lowest to highest, and statewide maximum rates are set using the 55th percentile of provider reported cost. Providers are required to bill their usual and customary charge (UCC) and they are paid at the UCC or the statewide maximum rate, whichever is lower. This process ensures that 100 percent of cost is covered for the most efficient 55 percent of the providers and provides an incentive for higher cost providers to lower their cost of providing service.

IV. PAYMENT FOR OBSTETRICAL AND PEDIATRIC SERVICES

A. MAXIMUM MEDICAID PAYMENT RATES FOR LISTED PRACTITIONER PEDIATRIC SERVICES

Procedure Code	Procedure Description	Unit Value	Factor	Maximum Payment
	1. OFFICE AND OTHER OUTPATIENT MEDICAL SERVICES			
	NEW PATIENT			
99201	Office & other outpatient visit, new patient, typically 10 minutes	N/A	N/A	$ 34.01
99202	typically 20 minutes	N/A	N/A	$ 53.63
99203	typically 30 minutes	N/A	N/A	$ 73.68
99204	typcially 45 minutes	N/A	N/A	$ 110.31
99205	typcially 60 minutes	N/A	N/A	$ 138.21
	ESTABLISHED PATIENT			
99211	Office and other outpatient visit, established patient, typically 5 minutes	N/A	N/A	$ 16.13
99212	typically 10minutes	N/A	N/A	$ 29.21
99213	typically 15 minutes	N/A	N/A	$ 41.42
99214	typically 25 minutes	N/A	N/A	$ 63.66
99215	typically 40 minutes	N/A	N/A	$ 100.72
	2. OFFICE OR OTHER OUTPATIENT CONSULTATIONS			
	NEW OR ESTABLISHED PATIENT			
99241	Office consultation for a new or established patient; typically spend 15 minutes	N/A	N/A	$ 28.34
99242	typically spend 30 minutes	N/A	N/A	$ 44.47
99243	typically spend 40 minutes	N/A	N/A	$ 57.60
99244	typically spend 60 minutes	N/A	N/A	$ 81.10
99245	typically spend 80 minutes	N/A	N/A	$ 109.21
	3. CONFIRMATORY CONSULTATIONS			
	NEW OR ESTABLISHED PATIENT			
99271	Confirmatory consultation for a new or established patient, usually presenting problem(s) are; self limited or minor	N/A	N/A	$ 24.88
99272	low severity	N/A	N/A	$ 37.09
99273	moderate severity	N/A	N/A	$ 52.53
99274	moderate to high severity	N/A	N/A	$ 69.35
99275	moderate to high severity	N/A	N/A	$ 95.62
	4. HOME SERVICES			
	NEW PATIENT			
99341	Home visit for the E/M of a new patient, usually the presenting problem(s) are; of low severity	N/A	N/A	$ 38.71
99342	of moderate severity	N/A	N/A	$ 50.69
99343	of high severity	N/A	N/A	$ 66.36
	ESTABLISHED PATIENT			
99351	Home visit for the E/M of an established patient, usually the patient is; stable, recovering or improving	N/A	N/A	$ 29.95
99352	responding inadequately to therapy or has developed a minor complication	N/A	N/A	$ 38.48
99353	unstable or has developed a significant complication or a significant new problem	N/A	N/A	$ 48.61
	5. PROLONGED SERVICES			
	WITH DIRECT (FACE-TO-FACE) PATIENT CONTACT			
99354	Prolonged physician service in the office or other outpatient setting requiring direct patient contact beyound the usual service; first hour	N/A	N/A	$ 53.22
99355	each additional 30 minutes	N/A	N/A	$ 53.22

Procedure Code	Procedure Description	Unit Value	Factor	Maximum Payment
	WITHOUT DIRECT (FACE-TO-FACE) PATIENT CONTACT			
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour	Bundled	N/A	Bundled
99359	each additional 30 minutes	Bundled	N/A	Bundled
	6. PREVENTIVE MEDICINE			
	NEW PATIENT			
99381	Initial evaluation & management of a healthy individual, new patient; infant (under 1 year)	N/A	N/A	$56.24
99382	early childhood (age 1 through 4 years)	N/A	N/A	$64.96
99383	late childhood (age 5 through 11 years)	N/A	N/A	$73.68
99384	adolescent (age 12 through 17 years)	N/A	N/A	$78.04
	ESTABLISHED PATIENT			
99391	Initial evaluation & management of a healthy individual, established patient; infant (under 1 year)	N/A	N/A	$43.60
99392	early childhood (age 1 through 4 years)	N/A	N/A	$52.32
99393	late childhood (age 5 through 11 years)	N/A	N/A	$60.60
99394	adolescent (age 12 through 17 years)	N/A	N/A	$64.96
	7. COUNSELING AND/OR RISK FACTOR REDUCTION INTERVENTION			
	NEW OR ESTABLISHED PATIENT			
	PREVENTIVE MEDICINE, INDIVIDUAL COUNSELING			
99401	Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 15 minutes	Noncovered	N/A	Not Cov.
99402	approximately 30 minutes	Noncovered	N/A	Not Cov.
99403	approximately 45 minutes	Noncovered	N/A	Not Cov.
99404	approximately 60 minutes	Noncovered	N/A	Not Cov.
	PREVENTIVE MEDICINE, GROUP COUNSELING			
99411	Counseling and/or risk factor reduction intervention(s) provided to healthy individuals in a group setting; approximately 30 minutes	N/A	N/A	Not Cov.
99412	approximately 60 minutes	Noncovered	N/A	Not Cov.
	OTHER PREVENTIVE MEDICINE SERVICES			
99420	Administration & interpretation of health risk assessment instrument (e.g., health hazard appraisal)	N/A	N/A	B.R.
99429	Unlisted preventive medicine service	N/A	N/A	B.R.
	8. NEWBORN CARE			
99432	Newborn care, in other than hospital setting, including physical examination of baby and conference(s) with parents.	Noncovered	N/A	Not. Cov.
	9. IMMUNIZATION INJECTIONS			
90700	Immunization, active; diptheria, tetanus toxoids, and acellular pertussis vaccine (DTaP)	N/A	N/A	$19.30
90701	diphtheria and tetanus toxoids and pertussis vaccine (DPT)	N/A	N/A	$12.89
90702	diphtheria and tetanus toxoids (DT)	N/A	N/A	$3.26
90703	tetanus toxoid	N/A	N/A	$3.00
90704	mumps virus vaccine, live	N/A	N/A	$20.06
90705	measles virus vaccine, live, attenuated	N/A	N/A	$18.30
90706	rubella virus vaccine, live	N/A	N/A	$18.73
90707	measles, mumps and rubella virus vaccine, live	N/A	N/A	$34.45
90708	measles and rubella virus vaccine, live	N/A	N/A	$25.67
90709	rubella and mumps virus vaccine, live	N/A	N/A	$27.42
90710	measles, mumps, rubella, and varicella vaccine	Noncovered	N/A	Not Cov.
90711	DTP and injectable poliomyelitis vaccine	Noncovered	N/A	Not Cov.

Procedure Code	Procedure Description	Unit Value	Factor	Maximum Payment
90712	poliovirus vaccine, live, oral (any type(s)	N/A	N/A	$15.82
90713	poliomyelitis vaccine	N/A	N/A	$18.55
90714	typhoid vaccine	N/A	N/A	$12.45
90716	varicella (chicken pox) vaccine	N/A	N/A	$46.43
90717	yellow fever vaccine	N/A	N/A	$48.34
90719	diphtheria toxoid	Not Covered	N/A	Not Cov.
90720	DTP and Hemophilus influenza B (HIB) vaccine	N/A	N/A	$32.01
90721	diptheria, tetanua toxoids, & acellular pertussis vaccine (DTAP) & hemophilus influenza B (HIB) vaccine	Not Covered	N/A	Not Cov.
90724	influenza virus vaccine	N/A	N/A	$6.35
90725	cholera vaccine	N/A	N/A	$4.88
90726	rabies vaccine	N/A	N/A	$108.31
90727	plague vaccine	N/A	N/A	$9.50
90728	BGC vaccine	N/A	N/A	$133.28
90730	hepatitis A vaccine	Not Covered	N/A	$52.64
90732	pneumococcal vaccine, polyvalent	N/A	N/A	$12.59
90733	meningococcal polysaccharide vaccine (any group(s))	N/A	N/A	$53.29
90737	Hemophilus influenza B	N/A	N/A	$20.58
90741	Immunization, passive; immune serum globulin, human (ISG)	N/A	N/A	$13.82
90742	specific hyperimmune serum globulin (eg, hepatitis B, measles, pertussis, rabies, Rho(D), tetanus, vaccinia, varicella-zoster)	N/A	N/A	B.R.
90744	Immunization, active hepatitis B vaccine; newborn to 11 years	N/A	N/A	$19.80
90745	11-19 years	N/A	N/A	$27.67
90749	Unlisted immunization procedure	N/A	N/A	B.R.

B. MAXIMUM MEDICAID PAYMENT FOR LISTED PRACTITIONER OBSTETRICAL SERVICES

Procedure Code	Procedure Description	Unit Value	Factor	Maximum Payment
	1. MATERNITY CARE AND DELIVERY			
	INCISION			
59000	Amniocentesis, any method	N/A	N/A	$107.72
59012	Cordocentesis (intrauterine), any method	N/A	N/A	$144.23
59015	Chorionic villus sampling, any method	N/A	N/A	$79.49
59020	Fetal contraction stress test	N/A	N/A	$50.92
59025	Fetal non-stress test	N/A	N/A	$54.99
59030	Fetal scalp blood sampling;	N/A	N/A	$85.25
59050	Fetal monitoring during labor by consulting physician with written report; supervision and interpretation	N/A	N/A	$41.47
59051	interpretation only	N/A	N/A	$38.02
	EXCISION			
59100	Hystrotomy, abdominal (eg, for hydatidiform mole, abortion)	N/A	N/A	$247.68
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	N/A	N/A	$368.87
59121	tubal or ovarian, without salpingectomy and/or oophorectomy	N/A	N/A	$301.59
59130	abdominal pregnancy	N/A	N/A	$328.78
59135	interstitial uterine pregnancy requiring total hysterectomy	N/A	N/A	$542.82
59136	interstitial uterine pregnancy with partial resection of uterus	N/A	N/A	$366.11
59140	cervical, with evacuation	N/A	N/A	$228.33
59150	Laparoscopic treatment of ectipic pregnancy; without salpingectomy and/or oophorectomy	N/A	N/A	$266.80
59151	with salpingectomy and/or oophorectomy	N/A	N/A	$374.17
59160	Curettage, postpartum (separate procedure)	N/A	N/A	$137.09
	INTRODUCTION			
59200	Insertion of cervical dilator	Bundled	N/A	Bundled

Procedure Code	Procedure Description	Unit Value	Factor	Maximum Payment
	REPAIR			
59300	Episiotomy or vaginal repair only, by other than attending physician; sinple	N/A	N/A	$79.49
59320	Cerclage or cervix, during pregnancy; vaginal	N/A	N/A	$104.60
59325	abdominal	N/A	N/A	$164.28
59350	Hysterorrhaphy of ruptured uterus	N/A	N/A	$208.51
	DELIVERY, ANTEPARTUM AND POSTPARTUM CARE			
59400	Routine obstetric care (all inclusive, "global" care) including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	N/A	N/A	$1,727.98
59409	Vaginal delivery only (with or without episiotomy and/or forceps;	N/A	N/A	$873.00
59410	including postpartum care	N/A	N/A	$982.07
59412	External cephalic version, with or without tocolysis	N/A	N/A	$72.12
59414	Delivery of placenta (separate procedure)	N/A	N/A	$67.74
59425	Antepartum care only; 4-6 visits	N/A	N/A	Not Covered
59426	7 or more visits	N/A	N/A	Not Covered
5944M**	Routine antepartum care, first trimester	N/A	N/A	$200.56
5945M**	Routine antepartum care, second trimester	N/A	N/A	$200.56
5946M**	Routine antepartum care, third trimester	N/A	N/A	$344.79
5950M**	Antepartum care only (Total trimester)	N/A	N/A	$745.91
59430	Postpartum care only (separate procedure)	N/A	N/A	$109.07
	**Procedure code assigned by State			
	Procedure code 59410 separated into two codes in 1994 CPT, 59409 and 59410.			
	Procedure code 59420 deleted in 1993 CPT. Replaced with 5950M reflected above.			
	CESAREAN SECTION			
59510	Routine obstetric care including antepartum care, cesarean delivery, and postpartum care.	N/A	N/A	$1,727.98
5947M**	Antepartum and postpartum care and assist at cesarean section	N/A	N/A	$942.32
59514	Cesarean delivery only;	N/A	N/A	$873.00
59515	including postpartum care	N/A	N/A	$982.07
59525	Subtotal or total hysterectomy after cesarean delivery	N/A	N/A	$582.30
	**Procedure code assigned by State			
	Procedure code 59515 separated into two codes in 1994 CPT, 59514 and 59515.			
	ABORTION			
59812	Treatment of spontaneous abortion, any trimester, completed surgically	N/A	N/A	$167.04
59820	Treatment of missed abortion, completed surgically; first trimester	N/A	N/A	$184.55
59821	second trimester	N/A	N/A	$170.50
59830	Treatment of septic abortion, completed surgically	N/A	N/A	$249.06
59840	Induced abortion, by dilation and currettage	N/A	N/A	$194.26
59841	Induced abortion, by dilation and evacuation	N/A	N/A	$261.03
59850	Induced abortion, by one or more intra-amniotic injections	N/A	N/A	$231.09
59851	with dilation and curettage and/or evacuation	N/A	N/A	$241.69
59852	with hysterotomy (failed intra-amniotic injection)	N/A	N/A	$324.17
59855	Induced abortion, by one or more vaginal suppositories (eg prostaglandin) with or without cervical dilation (eg laminaria);	N/A	N/A	$243.99
59856	with dilation and currettage and/or evacuation	N/A	N/A	$301.36
59857	with hysterotomy (failed medical evaluation)	N/A	N/A	$366.57
	OTHER PROCEDURES			
59870	Uterine evacuation & currettage for hydatidiform mole	N/A	N/A	$171.42
59899	Unlisted procedure, maternity care and delivery	N/A	N/A	B.R.